capitalhealth

CAPITAL INSTITUTE
FOR NEUROSCIENCES

HIPAA CONSENT TO RELEASE MEDICAL INFORMATION
Two Capital Way, Suite 456, Pennington, NJ 08534

Patient Name: _____DOB: _____ Date: _____

I. When we need to contact you regarding test results, prescription refills, rescheduling appointments, etc., please indicate where we can leave a message:

CIRCLE YES OR NO

HOME NUMBER ~ YES / NO _____

CELL NUMBER ~ YES / NO _____

II. MY PRIMARY CARE PHYSICIAN INFORMATION

Name:_____

Address: _____

Phone: _____

III. I AUTHORIZE THE FOLLOWING INDIVIDUALS TO RECEIVE INFORMATION PERTAINING TO MY MEDICAL CARE.

NAME	RELATIONSHIP	CONTACT NUMBERS

I agree _____to the above. Date Signed: _____
(***Patient Signature***)

Signing this form verifies all information is correct and/or has been updated.

Updated on 10/30/13